Christopher Woon L.Ac New Patient Intake Form

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorized consent.

Name_____Date_____
Address_____
City:_____State_____Zip_____
Phone# (Day)_____Evening_____
Birth Date:_____Age_____Height:_____Weight_____
Insurance I.D. #_____Referred by:_____
Occupation:_____Employer_____
Doctor's Name_____Phone _____
Diagnosis by your Doctor:_____

please circle area of problem

Major Complaint(s):_____

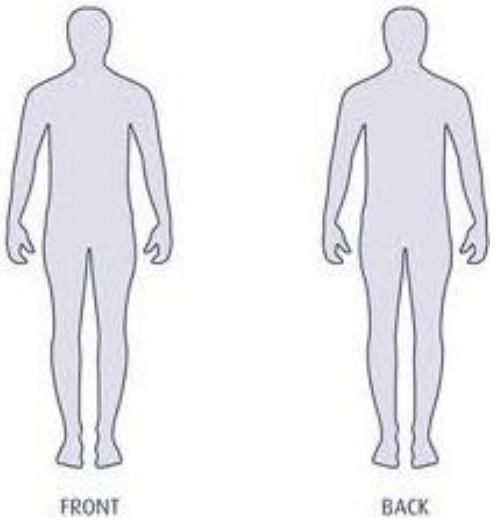
_____

_____

Other Complaint(s)_____

_____

_____



Pain is: O Minimal O Moderate O Severe
How long have you had this condition_____
Have you had this in the past O yes O no
When?_____
What makes it better?_____
What makes it worse?_____
Is your condition: O Getting worse O Constant
O Comes and goes
Medications/Drugs/Herbs you are currently taking?_____

_____

List surgeries/Operations you have had and dates_____

_____

Date of your physical examination:_____By whom:_____

MEDICAL HISTORY: (do you have, or have you ever had?) O Arthritis O Asthma OAnemia O Heart trouble O Cancer O Diabetes O Epilepsy O Stroke O Gallstone O high blood pressure O kidney or bladder trouble O Ulcers O Chronic Fatigue O Jaundice O sudden weight loss O sudden weight gain O other_____

Family history: (has any family member had any of the above?) O Yes O No
If yes, which member and what did they have?_____

_____

ENERGY LEVEL: O high (what time of day)_____O low (what time of day)_____
STRESS: O none O Moderate O Severe What cause it?_____

Sweating: Night sweaty rarely sweat Excess Sweating_____

Circulation: Feeling of hot or cold What area?_____
Bleed easily cold limbs other:_____
SKIN: Dry itchy Moist/ clammy burning Changing moles or lumps(cysts/tumors) boils frequent skin rashes Acne Hair loss/thinning Dry scalp skin puffy/winkled Hives Bruise easily (black and blue spots) Other:_____
SCARS:(list all scars from accident or surgeries)_____
_____
Sleeping problems: Trouble felling asleep Trouble staying asleep Excess dreaming Restful Other:_____ How many hours do you sleep at night_____
HEAD: Headaches (what area?)_____ Dizziness Memory loss loss of balance Other_____
EYES: Eye pain dry eyes blurred vision Darkness under eyes Other_____
NOSE: Frequent nose bleeds sinus trouble Frequent colds Other_____
THROAT: Sore throat Hoarseness Difficulty swallowing Teeth/gum problems jaw problems Swollen tongue Other:_____
CHEST: Hard to breath Wheezing Shortness of breath Trouble breathing at night Palpitations Mucus rattles when breathing Pain/pressure in chest Persistent cough Coughing blood Coughing phlegm:Sputum color_____ Other:_____
BLOOD PRESSURE: High.Low.Do not know
BOWELS: Diarrhea constipation Bloody stools Black stools Mucus in stools #bowel movements/day___ Hemorrhoids Lower bowel gas Stool have foul odor Colon problems other____
URINE: Frequent urination strong smelling urine Hard to urinate Blood in the urine Water retention Pain or burning when urinating Frequent infections Other_____
Musculoskeletal: Pain in the neck Shoulder Between the shoulders Arms/hands Hip Knee Fingers Big toe Upper back Mid back Lower back Loss of grip Bones sore/pain l Bursitis Swollen Knees/elbows Leg cramps at night Weakness in legs Weak ankles Stiff all over Tingling in feet Muscle spasm/cramp Painful joints Loss of feeling in hands/feet Other_____
NEUROLOGICAL: Nervousness Depressed Easily angered Easily Irritated Frequent crying WorryAnxiety Mood swings Memory loss Confusion Suicidal Poor concentration Tremors Numbness/tingling limbs Poor coordination Muscle weakness Feel weak/shaky Seizures Neuralgia(nerve pain) Shingles Other:_____
FEMALES: Pregnant? Yes No last monthly period_____ Last PAP test_____
Form of birth control: None Pill Other
Age started menstrual cycle___ Age stopped____ Color_____ Menstrual pain Low back Irregular Clotting Heavy Periods Light scanty bleeding Water retention Mood changes Missed period's Low or no sex drive Hot flashes Painful breasts Food cravings Other____ Discharges: Yellow Thick White Odor Itching Liquid Other_____ #Pregnancies____ #Deliveries____ #Miscarriages____#Abortions____#Cesareans___
Operations: Cervix Uterus ovaries Other_____
MALES: Low sex drive Impotence Ejaculation causes pain Premature ejaculation Discharge Pain or burning while urinating Prostrate problems Other_____

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DIGESTION: Stomach gas Lower bowel gas Heartburn Nausea Burning/belching Stomach pain Stomach cramps Vomiting Bad breath Sores in the mouth Weight gain Weight loss Bitter/sour taste in the mouth Abdominal bloating How long after eating?___ Food allergies? Yes No If yes, to What?_____

_____

Do you:skip Breakfast Eat a snack Eat a hearty breakfast
How many meals do you eat a day?____ What is the biggest meal of the day?____ Do you plan meals according to the" Four basic food groups"? Yes No
how many glasses of water do you drink per day? _____
Do you use alcohol? Yes No Amount per week_____ Type?_____
Tobacco ? Yes No Packs per day_____ how many years____

DO YOU:
Eat raw fruit or vegetables at least twice per day? Y N Always add salt at the table? Y N
Eat green or yellow veg. at least twice per day? Y N Eat frequently between Meals? Y N
Eat meat or dairy products 2+ times a day? Y N Eat until you are full? Y N
Chew your food thoroughly before swallowing? Y N Eat when you're not hungry? Y N
Eat the same foods almost every day? Y N Occasionally go on a crash diet? Y N
Drink juice, milk, or other drinks instead of water when thirsty? Y N

DO YOU:	ARE YOU:
Have a tendency to faint? Y N	Taking any therapies at this time? Y N
Bruise or Discolor easily? Y N	Hungry at present? Y N
Bleed easily ? Y N	Exhausted at present? Y N
Have or have had hepatitis? Y N	Nervous at present? Y N
Have excessive thirst? Y N	Allergic to anything? Y N

Individual treatment sessions typically are 45 minutes to 1 hour in length. It is important you are on time because your treatment time will not be extended beyond the scheduled time as a result of your late arrival. Your appointment time is held exclusively for you.If you are unable to keep your appointment for any reason, you must give at least **24 hours** to cancel. **Otherwise you will be charged a $50.00 fee for the time reserved for you. Insurance companies will not reimburse you or us for the missed appointment.** The fees for acupuncture codes are as follows, one or more code maybe billed per session.

New patient		Established patient	
99203	$120.00	99211	$50.00
		99212	$65.00
		99213	$75.00

Acupuncture			
97810 w/o electro stim initial 15 mins.	$85.00		
97811 additional 15 mins	$60.00		
97813 with electro stim. initial 15 min.	$90.00	97026 infrared	$25.00
97814 add'l 15 min with electro stim.	$65.00		

PATIENT SIGNATURE_____